Meeting Notes
Clinical Advisory Panel

May 16, 2001 - Cedars-Sinai Medical Center, Los Angeles

Panel Members Present – Antonio Linares, M.D.; Peter J. Panzarino, M.D.; Herbert A. Berkoff, M.D.; David Bergman, M.D.; John Alksne, M.D.; Edward Savage, Jr., M.D.

Introductions –Antonio Linares, M.D., Medical Advisor to the Director, opened the third meeting of the Clinical Advisory Panel.

Overview of Independent Medical Review - HMO Help Center Update - Alan Smith, IMR project Director, HMO Help Center, outlined the applications and reviews submitted during the first quarter 2001. The number of applications seem to be leveling off at about 130 per month. Approximately one third of the cases submitted for review are being overturned. The reasons for applications that are not considered eligible were described, along with the decision-making process involving the assessment of urgent calls received by the HMO Help Center nursing staff.

- The monthly report summarizing completed cases are going to be used in a redacted format for the HMO Help Center website. It is currently in a test mode and will be screened to avoid release of confidential information. Final action is expected by mid-June. Concern over HIPAA privacy concerns, as they relate particularly for behavioral health cases, was noted.
- Additional staffing for IMR has been assigned - four counsel are currently trained with another four attorneys will be working IMR cases; 15 additional service representatives being hired with six to be assigned IMR applications and cases, with a separate supervisor for the IMR representatives.
- Internal audit process of 25% of April reviews, assessing timelines and record requests from the overall system. Reports will go to Dr. Linares for quality of care component, with notes of any quality issues identified by the Call Center staff.

The Panel discussed making information about IMR publicly available. Plans are not going to be listed on the website although the Department will be tracking. The lack of notice to consumers was a concern and it was suggested that the Department could allow consumers to request that their case be taken off the website and suggested that disclosure about the disclosure could be included in the adoption letters to advise enrollees that a redacted version will be posted on the web.

IMR Quality Assurance Process - Dr. Linares described reviews that the Department must establish, including feedback and communications systems:

- Periodic reports, including costs of the IMR process, were described.
- Satisfactory and completeness of the medical review, reviewer conflicts of interest and how assignments are made to particular physicians need to be identified for feedback and assessment.

- How complaints about reviews will be addressed, both about the system overall and case specific concerns raised internally, from plans and from consumers and their physicians.
- Addressing overall data and grievance systems as they relate to the actions and responsibilities of the IMR contractors, plans, Department and legislative requirements.
- Ensuring that quality assurance and oversight responsibilities of the IMR processes are identified by the relevant involvement of the participants and actors in the IMR system and the respective responsibilities defined explicitly or implicitly.
- Focus on the number and types of specialties assigned in complex medical necessity cases. Alan Smith noted that CHDR consults with DMHC, in view of the increased complexity and costs relating to such cases since the contractual fees increase with the assignment of additional reviewers. Some medical directors have suggested outlining parameters for the types of cases that should be considered for multiple reviewers.

Dr. Linares reviewed the draft of an IMR comment and feedback form developed in conjunction with the CAHP medical directors. Dr. Alksne asked when the tool would be used - Dr. Linares suggested that it would be used when there were concerns or questions about a particular case, not a systemic assessment for every review submitted. Dr. Bergman noted that CHDR has requirements for reviewers to note the medical evidence relied upon in the determination, for example - if there is no discussion in the review, this should be caught in their internal QA systems. Dr. Linares noted that each panel member was provided with a sampling of cases, as discussed during the previous meeting.

- Dr. Panzarino had concerns about quality in the two cases - discrepancy in defining medical necessity in evidence-based decision-making and concerns about the capabilities and experience of the assigned reviewer in another case, believing that it was not provided to the appropriate specialist. He believed the third case he read was excellent.
- Dr. Alksne asked about the CHDR process since all three reviewers referenced the same materials. Dr. Linares noted that the appeal officer obtains the information from the plan and other information and provides it to the reviewers. They may pull other literature and references, independently. The Panel discussed the need for further explanation of the CHDR process in regards to what appears to be a cookie-cutter approach, a lack of references and citations to medical literature and the need to standardize reviews for consistent analyses and determinations. Dr. Alksne noted that since there is no appeal, it's crucial that the report be done correctly.
- Dr. Panzarino asked whether a re-review is warranted when the reviewer assigned was not qualified. Dr. Linares noted that this is a contractual obligation and they are required to have an internal quality assurance process that should catch such problems. Joyce Vermeersch noted that the statute didn't envision a role for the Department's assessment and resubmission. If the determination were erroneous, the Department wouldn't knowingly issue an order for the implementation of such a review. Dilemma in looking at each review presents a quandary since this would eliminate the purpose of the system. Dr. Linares noted that the Department is not staffed to review each case, but the contractor should. Dr. Alksne noted that from the perspective of the individual patient, he would deserve a re-review rather than the system improvement.

- Identification of patient demographics and sources of IMR issues would be useful, along with assembling the evidentiary basis for the reviews.
- Dr. Savage noted that there didn't seems to be enough information presented regarding the dispute in an IMR case he reviewed but would not want the Panel to become engaged in assessing the entire IMR case file. Dr. Bergman noted that the Panel could assess the case for the qualifications of the reviews and whether the assessments adequately respond to the issues presented.

Dr. Linares summarized the Panel member discussions of the cases that they review as requiring further information about the qualifications and assignments of reviewers and consistency in the standards they are held to. The Department needs to put an oversight system in place, allowing input from medical directors and the consumers, to ensure that the processes and results are fair for everyone.

The Department has recognized that there must be effective and stringent oversight over the clinical aspects of the IMR process. Medical quality review processes will be performed through U.C.S.F. to define systematic audits and to assist the Clinical Advisory Panel. Capturing the information and concerns from the plans and others will serve to give feedback to the review organization and the interagency agreement can consolidate and evaluate the clinical aspects presented by the plan and IMR decisions.

- Dr. Linares will meet with the CHDR medical director as soon as possible with the HMO Help Center and with Department counsel. Panel members will fill out the forms on the cases that they've reviewed. Intensified ability to provide oversight through regularly scheduled meetings, including the plan medical directors. Setting standards for the number and type of reviewers.

Dr. Alksne discussed the process of posting IMR results on the DMHC website and asked for clarification on the rules to be applied in the posting and the obligations it creates for the Department. Further details on the procedures and rules the Department will apply to making the information available to the public and plans.

American Association of Health Plan assessment of Independent Medical Review discussion.
A discussion on the recent report on how evidence-based external reviews can contribute to improve delivery of services by managed care organizations was led by Dr. Alksne. The Panel noted:

- The concern that requiring reviewers be licensed in the state introduces problems relating to independence and located truly qualified reviewers for the disputed therapy - the California system requires that California physicians be given preference for reviews.
- Using evidence-based medicine process to ensure that the review is medically sound and can lead to systemic changes in plans is critical. The quality for the search for information is critical, since searching on the Internet is a skill, as well as synthesizing the information found. Need to dialogue with CHDR in searches and synthesizing the information found is important and should be discussed with CHDR.

- Determining qualifications in a specific subspecialty goes beyond just board certification. Dr. Bergman would like to know whether reviewers treat the types of patients and are not authors of any articles that advocate a particular viewpoint.
- Dr. Alksne noted comparison with the overturn rates from other states could illustrate whether the California system is providing satisfactory results. Dr. Linares noted that there are limitations in how different systems can be compared to each other, particularly since IMR and other statutes change plan practices.
- Joyce Vermeersch asked whether the Panel believed that the comments concerning inter-relator reliability in the report were valid. Members of the Panel noted that the concept would be desirable but not reflected in standard medical practice. While desirable, the complexity of many IMR cases would also make it difficult to make direct comparisons. A member suggested that the review organization should periodically send a test case sent out to compare the results as part of their continuous quality improvement.
- Another question is whether the reviewers are actively practicing or are spending most of their time in drafting reviews rather than practicing "cutting edge." The Department should find out what reviewers' level of clinical practice. Literature reviews and search engine use should be evaluated but the depth and complexity of the case would be determinative.

Abstracting the information from the article that is useful to the California process will be taken up with CHDR.

Public Comment -

Kathy McCaffrey, Vice President Health Care Data and Operations, CAHP: Several issues have arisen since Dr. Linares attendance at the quarterly medical directors' meeting. Very important for the plans to know about the statistics and how the cases come out. Feedback is critical to the plans - some have had experience with CHDR in Medicare and others have not. She shared concerns from PacifiCare about conflict of interest in the CHDR contract that might restrict having knowledgeable "cutting edge" clinicians involved in the reviews, especially if there are preferences for California-licensed reviewers. A suggestion has been made for a checklist or other tool for journal articles, clinical experience in the procedure or related items that could limit the questions arising in the reviews. Dr. Alksne noted that these checks should be part of their contractual responsibilities. She questioned whether the organization's experience with Medicare might impact on how they are approaching California cases. Dr. Linares noted that one concern is the degree to which CHDR is using the number of Medicare reviewers for the California IMR project.

Informational Items -

- **Institute of Medicine report, "Crossing the Chasm" was discussed by Dr. Linares.** He noted that the AAHP report reference the IOM report's discussions about evidence-based medicine. The recommendations in the report should be fully considered by the Department and the basis for further focus groups and development of standards for IMR. Dr. Alksne noted that many recommendations are made toward the federal government and asked whether resources have been

allocated. Dr. Bergman noted that there had been significant funds dedicated following the first report. He also suggested that some plans do a good job on chronic illness and disease management and it would be good to raise the bar for other plans to publicize what some plans have accomplished. He suggested that Dr. Ed Wagner of McCall Institute could be invited and identify the stellar programs. Dr. Alksne noted the efforts of the Quality Performance Measurement subcommittee, currently working on the uniform quality audit system for providers that would have more impact than the case-by-case IMR resolutions.

Dr. Neil Romanoff, Cedars-Sinai Medical Center, discussed quality initiatives and quality management experiences. Dr. Romanoff noted that while he will address how the Medical Center has addressed quality improvement in the context of the hospital environment but that their processes and ideas can be evaluated and implemented in different contexts. The purpose and the end result are to create an error-free environment and improve the quality of care - not to fill out forms or to meet JCAHO requirements. The latter are simply tools to get to that end result – the goal should not be forgotten. The quality structure and strategic planning for quality improvement at the Medical Center have been developed on an annual basis in the strategic plan, identifying goals to be achieved by the Center and the medical staff, all aligned and working together. Collaborative efforts and committees also exist with nurses and others, all building toward meting the organization's strategic goal. A quality council meets weekly to assess measures that are developed regularly. A series of committees throughout the Center with information flowing up and down the system.

- Electronic ordering project soon will come on line that will include practice guidelines and require explanations for deviations. The data gathered will be subject to peer review. Models for clinical improvement include those drafted by the Institute for Health Care Improvement, requiring clear aims and measures with tests and changes to run from data. Failures are encouraged to test assumptions. Another tool is used, the quality compass from Dartmouth. Data is key and has been a primary focus - each month, data elements are published with commentary such as patient satisfaction, operating room turnaround, and patient falls, for example, that are all built around measures.
- Sentinel event reporting under JCAHO was expanded by the Center to include "significant adverse events" which includes "near misses. They have learned a lot from the past three years' of reports, demonstrating the advantage of having specific processes for handling and processing information. Important to design flow structures with recommendations and timeframes and periodic reviews to make sure the problems have been addressed since they have identified deterioration in results attributable to turnover that diffuses the learning and correction problems.
- Joint Commission's "core measures" essentially are measures for about a half dozen diagnoses – this has been added to previous measures tat had been adopted earlier as clinical guidelines by the Center. Every Wednesday, meetings with five charts pulled for each core measure for a small random sampling as part of their continuous evaluation, which can tell whether there is improvement. This approach is doable without a massive database/informational system. Each measure identified by "owner" (department) with set goals for periodic performance. Data will be published publicly next January – it's the "right stuff" to do for a series of diagnoses. E.g.,

beta-blockers within 24 hours after an MI. They are derived from hard-core evidence that can be established and verified from the research and literature. Limited to high volume, high opportunity diagnoses – when incidents don't allow for dedication of resources, individual departments can use the tools and studies if they want to assess a smaller study. Results are posted with senior management getting the breakdown and tracking of the results on a macro scale, with the specific data available.

- Peer review process and structure mapped out in order to follow the decision points, far easier than textual. New information system can generate information reports from the database from peer review and patient complaints.
- Questions from the Panel.
    - The number of physicians and staff assigned to the Center's quality oversight function is difficult to establish since participation varies from case-to-case. The central quality improvement department has three chart reviewers, each with departmental assignments. Including physicians, a total of about 16 people work in QI. On a voluntary basis, physicians screen identified charts that may then go to identified committees. Sentinel events are managed by one RN, with root cause analysis teams of three or more, in addition to input as needed from the departments concerns. Clinicians are teamed with operational staff at the departmental level groups.
    - When there is a clear process outcome in the peer-reviewed literature and he measure accepted, they will adopt that standard and not seek to re-validate. Resources are devoted to making sure that the clinical performance is maintained but results are not checked unless there are further studies.
    - There are two files maintained on physicians – the credential file and the physician quality profile (PQP) with patient complaints, DRG patterns, procedures performed, post-operative complications and re-admissions.

Diabetes guideline stakeholders meeting update by Dr. Linares. Dr. Linares noted that some Panel members asked about other collaborative efforts - CCHRI guidelines in March and in April AMA, JCAHO and NCQA joint guidelines on diabetes management. He noted there now is a significant body of information on chronic disease management with next step to have a stakeholders' meeting and highlight their results and findings.

A.B. 88 – Mental Health Parity. In regards to behavioral health, Dr. Linares noted that he had met with Governmental Affairs Committee of the California Psychiatric Association. The CAP had previously heard about issues relating to AB 88 implementation and the Department had solicited any messages that need to relay to the legislature. Under consideration is identifying an academic or research group to find issues relating to carve outs and related access issues and child and adolescent access to behavioral health services.

Dr. Linares introduced Dr. Graff who described the Association's AB 88 implementation task force. AB 88 with parity for a limited list of diagnoses led to the creation of a 15-physician committee, chaired by Dr. Dick Chandon. The initial focus was on the services for children services which seems to present the most difficult challenge – the committee hopes to have a series of stakeholder meetings that

will include other disciplines such as corrections, welfare and educational service developmental disabilities, regional center, child protective services, foster and adoption and safety agencies since they all are interrelated in access and providing services.
The basic principle for the committee is to provide services based on evidence-based practice. For child psychiatric services, the problem often is the diffuse responsibility to provide services. IEP is a classic example when school systems face financial pressures if they identify a child needed the services.

- Quality assurance standards and technical expertise will be needed in this area – American Psychiatric Association has published a series of treatment guidelines. Overall, the Association believes it is time for it to step up to the table, with the other disciplines and governmental agencies, to work together. Mental health has sometimes been forgotten in the comprehensive delivery of health care services since patients have been traditionally relegated to distant sites. That has changed and psychiatry has come much closer to other medical practice through medication and clinical progress in treatment. Unlike other medical practices, a significant issue in mental health are non-delivered services - there often is simply no care, both in rural and inner city
- Child psychiatrists are stretched to the limit in California and very difficult to get into networks. Each mental health discipline has a specialty group for children services. Similar effort in insurance industry although he doesn't believe it has progressed too far.

In response to Dr. Bergman, Dr. Graff noted that the outcomes from such a meeting would hopefully the development of a process that sets forth measures for improvement. Kathy McCaffrey asked about regulations for A.B. 88 and noted that the CAHP feels this would help provide parameters over plan obligations. Dr. Linares noted that DMHC should determine what its role can or should be in such a meeting

Next Steps – Dr. Linares. Dr. Linares summarized the issues and areas discussed that should be considered for Department action and subsequent meetings:

- Stakeholder meetings regarding mental health parity and diabetes practices.
- Dr. Linares will be meeting with CHDR for review of IMR issues and the comment forms for intensive oversight.
- Office of Standards and Research should research several areas on additional IMR standards requiring definition.
- Next meeting in August, proposed at Stanford Medical Center hosted by Dr. Bergman.

[Corrections or comments regarding these notes should be provided to Tom Gilevich, DMHC Counsel at (916) 324-9024; FAX (916) 322-3968; TGilevich@dmhc.ca.gov.]